

MH 556
09/11/06**OUTPATIENT
MEDICATION REVIEW**

I have talked with my psychiatrist, Doctor _____, who has recommended that I / my child receive(s) medication(s) to treat symptoms of: _____

The type(s) of medications prescribed is checked below:

☐ Antidepressant ☐ Anxiolytic ☐ Mood Stabilizer ☐ Antipsychotic ☐ Other _____

| Medication(s) | |
|---------------|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/frequency during the course of treatment will be discussed with me.

I have been informed that some side effects are possible, including:

- ☐ Muscle stiffness/tremor ☐ Drowsiness ☐ Dry mouth/blurred vision/constipation
☐ Nausea/appetite changes ☐ Sexual problems ☐ Pregnancy issues ☐ Dizziness
☐ Interactions with other drugs, food & health conditions ☐ Diabetes ☐ Weight Gain
☐ Other _____

I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or other staff member about changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed for other conditions.

With some anti-psychotics I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.

I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist any decision to stop taking medication.

I understand that my psychiatrist believes this medication will help me, but there is no guarantee as to the results.

- ☐ I HAVE READ THIS FORM ☐ THIS FORM HAS BEEN READ TO ME
☐ THIS FORM HAS BEEN VERBALLY TRANSLATED INTO _____ FOR ME.

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME, AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED.

Signature: _____
(Client)

Signature: _____
(Parent/Legal Guardian/Conservator)

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature: _____
(Psychiatrist)

Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Name:

MIS #:

Agency:

Prov.#:

Los Angeles County - Department of Mental Health

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